

**STATE PLAN FOR MEDICAID PROVIDER REIMBURSEMENT**

**Long-term Care including Intermediate Care Facilities for the Mentally Retarded**

Long-term care services and intermediate care services for the mentally retarded are paid for Medicaid recipients by means of rates determined in accordance with the following principles, methods and standards which comply with 42 CFR 447.250 through 477.272. Assurances, findings and related information required by 42 CFR 447.253 and 447.255 have been transmitted separately and are not included in the description of the following payment methodology.

**I. Introduction:**

Rate setting principles and methods are contained in Alaska Statutes 47.07.070 - 47.07.900 and administrative regulations in Alaska Administrative Code 7 AAC 43.

Data sources used by Medicaid Rate Advisory Commission (Commission) and the Department of Health and Social Services (Department) are the following:

1. Medicare Cost Reports for the facility's fiscal year ending 24 months before the beginning of the facility's prospective rate year.
2. Budgeted capital costs, submitted by the facility and reviewed and adjusted by the Department as appropriate in accordance with Section II, for the rate year on capital projects or acquisitions which are placed in service after the beginning of the base year and before the end of the rate year and for which an approved CON (Certificate of Need) has been obtained.

A CON is required for certain expenditures of \$1,000,000 or more. Some situations requiring a CON include major alterations or additions to buildings, any addition or elimination of a major type of care in or through a facility, and any change in licensed beds within a two year period amounting to 10 beds or 10 percent of total beds.

3. Operating budgets, as applicable, submitted by new Medicaid providers.
4. Historical financial and statistical information submitted by facilities for past rate setting years.
5. Utilization and payment history provided by the Division of Medical Assistance.

**II. Allowable Costs:**

Allowable costs are documented costs that are ordinary and necessary in the delivery of a cost effective service. Allowable costs are those which directly relate to Title XIX program recipients. They are costs which must be incurred by an efficiently and economically operated provider. Costs would include those necessary to conform with the state and federal laws, regulations, and quality and safety standards.

Most of the elements of Medicaid allowable costs are defined in Medicare and reported, subject to audit, on the Medicare Cost Report. The following items are possible adjustments from financial statement classifications to Medicaid classifications, and may be reflected either within the Medicare Cost Report or elsewhere in the Medicaid cost finding process.

- \* return on investment is not an allowable cost for any facility.
- \* advertising cost is allowable only to the extent that the advertising is directly related to patient care. The reasonable cost of only the following types of advertising and marketing is allowable:
  - announcing the opening of or change of name of a facility.
  - recruiting for personnel.
  - advertising for the procurement or sale of items.
  - obtaining bids for construction or renovation.
  - advertising for a bond issue.
  - informational listing of the provider in a telephone directory.
  - listing a facility's hours of operation.
  - advertising specifically required as part of a facility's accreditation process.
- \* nursing staff in a long-term care facility is allowable as a routine cost only.
- \* physician compensation costs and charges associated with providing care to patients are not included as an allowable cost.
- \* medical services which a facility is not licensed to provide are not included as an allowable cost.
- \* costs not authorized by a certificate of need when a certificate of need is required are not included as allowable costs.

- \* pharmaceutical supplies and materials paid under other programs are not included as an allowable cost.
- \* management fees or home office costs which are not reasonably attributable to the management of a facility.

Allowable patient related costs include wages, salaries, and employee benefits, purchased services, supplies, utilities, depreciation, rentals, leases, taxes, excluding local, state and federal income taxes, interest expense. A facility must reduce operating costs by the cost of all activities not directly related to health care. Other specific nonallowed costs are bad debts, charity, contractual adjustments and discounts taken by payers.

A Certificate of Need is required for certain expenditures of \$1,000,000 or more. Situations requiring a CON can include major alterations or additions to buildings, any addition or elimination of a major type of care in or through a facility, and any change in licensed beds within a two year period amounting to 10 beds or 10 percent of total beds. If a certificate of need is required on assets purchased after July 1, 1990, the amount of capital costs included in the rate calculation will be limited to the amounts described within the certificate of need application and other information the facility provided as a basis for approval of the certificate. In determining whether capital costs exceed those amounts approved under a certificate of need, and for determining the maximum prospective per diem rate approved under a certificate of need, the Department will consider:

- (1) the terms of issuance describing the nature and extent of the activities authorized by the certificate; and
- (2) the facts and assertions presented by the facility within the application and certificate of need review record, including purchase or contract prices, the rate of interest identified or assumed for any borrowed capital, lease costs, donations, developmental costs, staffing and administration costs, and other information the facility provided as a basis for approval of the certificate of need.

### **III. Inflation Adjustments:**

Allowable costs are determined by adjusting base year data. Base year data will be the allowable operating costs excluding capital costs in the facility's fiscal year ending 24 months before the prospective rate year. For facilities whose fiscal year began July 1,

1997, the most current or fiscal year would be the fiscal year beginning July 1, 1994. The allowable base year costs are adjusted for inflation. Inflation is calculated annually using projected inflation indices developed based on data available in May prior to the facility's fiscal year beginning.

Substantial amounts of different economic and inflationary data sources are utilized to arrive at the most accurate Alaska inflationary factor possible. National inflation projections and economic trends such as those published by Data Resources, Incorporated and ACCRA (cost of living index) are utilized. Regional inflationary data that the Department has available is given consideration during the evaluation of inflation rates to be set. In addition to the published economic and inflationary reports considered in the analysis, the Department also considers recommendations of the Medicaid Rate Advisory Commission in the development of the inflation factors. Inflation is projected on a compound rate over a three year period of time. Inflation forecasts are developed based on anticipated changes in inflation using a HCFA type market basket.

The inflation factors applied to the long-term care services are as follows:

The three year average compounded inflation rate will be 6.6%.

Inflation rates for the following years will be used:

1995	2.9%
1996	1.7%
1997	1.9%

Compounding of inflation factors create a situation where the total is greater than the three years inflation factors. The adjustment then allows the inflation factors to be used independently. This results in allowable increases of costs attributed to inflation between 1994 and 1997 of 6.6%.

#### **IV. Determination of Payment Rates:**

The prospective payment rate for long-term care facilities is a single per diem rate with identified base capital and acquisitions which are placed in service after the beginning of the base year and before the end of the rate year and for which an approved CON has been obtained, routine and ancillary components. Ancillary costs include physician ordered patient specific billable services such as medical supplies charged to patients, respiratory therapy, physical and occupational therapy. Allowable costs are necessary and ordinary operating expenses including capital and insurance costs.

The base year operating expenses less base year capital are inflated by the indices described in Section III. Principal payments on debt are not included in capital costs. Base year capital is tested for reasonableness by comparing projected changes in capital expenditures and calculated using the greater of actual patient days or 85 percent of available licensed capacity days.

#### **BASE YEAR**

These methods and standards are revised to provide for a rebasing of costs incorporated into the rate calculation process for facilities with prospective fiscal years beginning January 1, 1997 through December 1, 1997. Base year and approved year financial and statistical information will be identical in rate calculations for facilities with fiscal years beginning during that time.

The reasonableness test is applied to not allow the rolling base year to unduly reward or penalize the providers. For example, the allowable costs per patient day (base) are subjected to a test of reasonableness where the 1994 base plus inflation is compared to the 1996 approved rate. For providers who maintain costs at a level less than the base plus inflation, the provider will be allowed to retain 50% of the savings up to 5% of the base. For the providers who have not maintained costs within the approved 1996 rate when inflation is added to the base, the provider will be able to keep only 50% of the difference not to exceed 5% of the base.

Allowable costs for routine services per day less capital as calculated in the base year are adjusted to reflect inflation between 1994 and 1996. This cost per day is compared to the approved cost per day in the 1996 year. The following adjustments are made:

1. If the base year costs exceed the approved costs, the allowable costs for 1997 will be limited to the 1996 approved costs plus the inflation between 1996 and 1997 plus 50% of the difference between the allowable costs of the two years limited to 5% of the costs in the 1994 base year.
2. If the base year costs are less than the approved costs, the routine service costs will be calculated using the 1994 allowable base costs plus inflation identified in the inflation section plus 50% of the difference between the two years limited to 5% of the costs in the 1994 base year.

Ancillary costs are built into the single calculated per diem rate. Actual ancillary costs are calculated from the 1994 base year costs less long-term care prescription drug costs.

The costs are separated between base year capital and noncapital allowable costs. Inflation is added to the non-capital costs.

Ancillary and routine capital costs in the rate year are allowable facility base year capital costs, plus Department determined capital costs on CON approved capital additions which are placed in service after the beginning of the base year and before the end of the rate year.

A 1997 example of the calculation of allowable routine costs for a January 1 facility is as follows:

	<u>1994 BASE</u>	<u>1996 APPROVED</u>
Operating Expenses	\$2,707,182	\$2,861,358
Inflation on Base Year 1994-1996	<u>124,503</u>	
Total	\$2,831,685	\$2,861,358
Units of Measure	13,803	13,949
Rate per patient day	<u>\$205.15</u>	<u>\$205.15</u>
Total	\$205.15	\$205.15
Difference (Base-Current)	(0.00)	
50% of Difference	0.00	
5% of Base	\$9.81	
If Difference is Negative:		
Add 6.6% Inflation to Base	12.95	
Plus 50% or 5% whichever is less	0.00	
If Difference is Positive:		
Add 1.90% Inflation to Approved		
Plus 50% or 5% whichever is less		
1997 Allowable Routine Rate Per Patient Day	\$209.08	

For FY 1997 each facility will be rolling off of their base year of 1994. For fiscal years after 1997 this calculation will be utilized to determine if the base year allowable routine rate will be based on the approved or the base year actuals. The determination process is outlined in BASE YEAR explanation.

The example for routine costs outlines the rate process where the 1994 base year costs equal the 1996 approved costs. The 4.6% inflation factor represents the Commission approved inflation between 1994 and 1996 for January 1 facilities. The 4.6% inflation is

added to the 1994 routine costs per patient day for comparison to the 1996 approved rate per patient day. (The rate is adjusted by 50% of the difference between the 1994 rate and the 1996 rate not to exceed 5% of the 1994 rate.) In the example shown, 5% of the base is greater than 50% of the difference. Therefore, the 5% factor is used.

Calculation of Actual Allowable Ancillary Costs Per Patient Day 1997 rate example:

**LONG-TERM CARE**

Base Expenses	\$156,443
Inflation (6.60%)	<u>10,325</u>
Total Allowable Base Expenses for 1997	\$166,768

\$166,768 divided by 12,472 equals \$ 13.37

Ancillary costs are calculated by inflating the 1994 actual Medicaid ancillary allowable costs less base year capital per patient day by the inflation factor identified in Section III. This Medicaid ancillary cost is divided by the Medicaid patient days from the 1994 base year.

The actual allowable ancillary costs are related to Medicaid patients only. The base year actual allowable costs are arrived at by dividing the lower of cost or charges into the allowable costs and then multiplying by Medicaid ancillary revenue. Allowable ancillary costs are limited to allowable Medicaid ancillary charges, which are reported by the facilities on the Medicare Cost Report worksheet D. The worksheet D ties to the facilities working trial balance as the amount charged to their Medicaid patients.

For the entire period, the total allowable Medicaid costs in the base year are then divided by the base year Medicaid patient days. For rates established on or after July 1, 1990, the cost of prescription drugs is not included as an ancillary cost. Prescription drug costs and charges are removed from the calculation of actual allowable ancillary costs through information provided by the individual facility, or if not available from the individual facility, from a sample of information submitted from other facilities.

Capital acquisitions not subject to CON approval and obtained after the base year are not included in the budgeted portion of rate year capital costs.

For the calculation of rate year capital costs, projected capital costs for post base year CON approved additions are included in the rate year during the first 3 rate years of asset use if the CON addition is estimated to be placed in service during or before the rate year.

No projected costs are added to the rate year capital for post base year acquisitions not subject to a CON. No costs are allowed for additions pending CON approval or for capital for which a CON was required and not obtained.

Newly constructed facilities shall have the rate set for the first three years at the Alaska Medicaid swing bed rate in effect at the start of the facility's rate year less the average capital costs contained in the swing bed rate plus the appropriate inflation factor. Capital costs identified by the facility are added to the rate using the greater of the occupancy rate approved in the certificate of need or assuming an 80% occupancy rate.

If a facility is granted a Certificate of Need to construct additional beds, the overall facility base year occupancy statistics will be adjusted for the first three rate years during which the additional beds are available for occupancy to reflect 50 percent of the base year occupancy for the additional beds.

**V. Sale of Facilities:**

For facilities acquired on or after October 1, 1985, the increase in the depreciable base is limited to one-half of the percentage increase since the date of the sellers acquisition, in the Dodge Construction Systems Costs Index for Nursing Homes, or, one-half of the percentage increase in the consumer price index for all urban consumers, whichever is less. All related operating costs including interest are limited to the allowable changes in asset base. No facilities were sold or acquired between 1982 and October 1, 1985 or subsequent to October 1, 1985.

In addition, the recapture of depreciation expense on disposition of assets that accommodate gains under the Medicaid program will be limited by the provisions of 42 CFR 447.253(d) of the Code. Payment for acquisition costs associated with buying and selling of the facility will be limited by the provisions of 42 CFR 447.253 (d) of the Code.

**Example of Purchase Limitations**

**Historical Costs**

Book Value	\$5,000,000
Accumulated Depreciation	<u>2,500,000</u>
Net Book Value	\$2,500,000
Annual Depreciation	\$ 200,000
Long-term Debt	\$1,000,000
Interest on Debt	\$ 100,000
Allowable Costs	<u>\$ 300,000</u>
Purchase Price	\$8,000,000
Depreciation	\$ 400,000
Long-term Debt	\$6,000,000
Interest on Debt	\$ 600,000
Operating Costs	<u>\$1,000,000</u>
Change in CPI (Since original acquisition)	25%
Dodge Index	35%
Allowable change 25% divided by 2 = 12.5%	
New Depreciable Base	\$5,600,000
Accumulated Depreciation	<u>2,800,000</u>
Net Value	\$2,800,000
Depreciation	\$ 224,000
Allowable Interest Based on 40% debt prior to purchase on net value at historical 10% rate (\$2,800,000 X 40% X 10%)	<u>\$ 112,000</u>
Allowable Costs	\$ 336,000